Name: FMP/SSN last four: DOB:

Appointment Date: Contact Number:

5-11 YEAR VISIT

Do you have any specific concerns today? _____

_____

Any recent ER visits? ❑Yes ❑ No **When:** _____ **Reason:**_____

*****(Please complete information below: If filled out before, list only changes since the last visit.)*****

Chronic Medical Conditions (Circle all that apply)	Surgeries/Hospitalizations (Dates)	Family History (biological siblings, parents, grandparents)	Medicines (PLEASE INCLUDE DOSAGE)
Hay fever/Allergies **Asthma** **ADHD** **Overweight** **Chronic ear infections** **Other:**		**Hay fever/Allergies** **Asthma** **Other:**	**(Include over-the-counter meds, Tylenol, Motrin, vitamins, herbal supplements):** Does your child ever forget to take these medications? ❑ Yes ❑ No

Check if anyone in the family has had:

□ High Blood Pressure □ Sudden Death □ Hypertrophic Cardiomyopathy □ Genetic or Metabolic Disease

□ High Cholesterol □ Long QT syndrome □ Obesity □ Mental Illness

□ Heart attack < 50 years □ Diabetes

Please list any known allergies your child has (drug, food, latex) _____

Is your child enrolled in the Exceptional Family Member Program (EFMP/Q-coded)? ❑ Yes ❑ No

Is the child's sponsor currently deployed? ❑ Yes ❑ No Is this visit **deployment** related? ❑ Yes ❑ No

Is either of the child's parents on PRP status? ❑Yes ❑ No

Are your child's immunizations up to date? ❑ Yes ❑ No ❑ Unsure

Who does your child live with? _____

Does your child attend: ❑ DOD school ❑ British School ❑ Home-schooled (Grade: ____) ❑ Aftercare **Concerns?** ❑ Yes ❑ No

Does anyone in the family smoke? ❑ Yes ❑ No

Do you & your child feel safe at home? ❑ Yes ❑ No

What is your preferred method for learning: ❑ Verbal ❑ Written ❑ Visual ❑ Other: _____

Preferred language: ❑ English ❑ Other: _____

Are there cultural or religious considerations that affect your child's healthcare? ❑ Yes ❑ No _____

Check if your child has had a history of:

□ Trauma □ Fractures □ Fainting during exercise

□ Head Trauma □ Chest pain or discomfort □ Exercise intolerance

□ Concussion □ Palpitations □ Headaches

Diet/Exercise History:

Is your child a picky eater? ❑ Yes ❑ No **Does your child usually eat large portions or multiple servings?** ❑ Yes ❑ No

# of servings of fruits & vegetables per day? ____ **# of times per week eating fast food**? _____

Do you usually eat dinner as a family? ❑ Yes ❑ No **Does your child usually eat breakfast?** ❑ Yes ❑ No

Drink milk? ❑ Yes ❑ No How many ounces per day? _____ **Type of milk?** ❑ Whole ❑ 2% ❑ 1% ❑ Skim

Drink juice? ❑ Yes ❑ No How many ounces per day? _____ **Caffeinated beverages?** ❑ Yes ❑ No How many per week? ____

Does your child get at least one hour of physical activity at least 5 times per week? ❑ Yes ❑ No Type of activity: _____

How many hours of exposure to TV/video games/computer time does your child have per day? _____

Does your child have a TV or internet in their bedroom? ❑ Yes ❑ No **Hours of sleep per night?** _____

Check all of the following that apply for your child:

❑ Appropriate Behavior at Home	❑ Pride in achievements
❑ Appropriate Behavior at School	❑ Talks about activities at school
❑ Appropriate Behavior when playing with friends	❑ Completes school work
❑ Reading and doing math at grade level	

Circle if you have any concerns about the following: Bowel movements / Sleep problems / Bedwetting/ Vision / Hearing

Pre-teen/teen females only (if applicable): Last menstrual period _____

Weight		Visual Acuity: R 20/____ L 20/ _____ Both 20/ _____
Height		Pain: ❑ Yes ❑ No Location of Pain _____
BMI/%		
BP		Technician Signature:_____
		Imm UTD per ASIMS: ❑ Yes ❑

HPI:

NE	Examination:	Normal	Abnormal
□	**General:**	□ Active/Alert/WN/WD/NAD/ not dysmorphic	□
□	**Head/Neck:**	□ NCAT, FROM, Neck supple, Nl thyroid, Nl lymph nodes	□
□	**Eyes:**	□ PERRL, RR X2, nl corneal reflex, EOMI, no strabismus	□
□	**R ear:**	□ TM gray/nl landmarks, nl pinna/ext ear canal	□ Bulging/immobile/red
□	**L ear:**	□ TM gray/nl landmarks, nl pinna/ext ear canal	□ Bulging/immobile/red
□	**Nose:**	□ Patent, No congestion/discharge	□ Congested
□	**Oropharynx:**	□ Pink, moist, no lesions □ Teeth: Nl, no signs of caries	□
□	**Lungs:**	□ CTAB, no retractions, nl WOB	□
□	**CV:**	□ RRR, no murmur, strong arterial pulses, cap refill < 2 sec	□
□	**Abd:**	□ Soft, NT, no HSM, no masses, nl BS	□
□	**Ext/Spine:**	□ NL, FROM, nontender, no edema, spine straight	□
□	**Skin:**	□ No rash/skin lesions	□
□	**Female:**	□ Nl breasts/Tanner ____ □ Nl ext genitalia/Tanner____	
□	**Male:**	□ Nl penis, Nl scrotum, Testes down, Tanner ____, No hernia	
□	**Neuro:**	□ Nl tone/strength/DTRs/balance/gait □ CN II-XII intact	□
□	**Other findings:**	□	□

LABS/X-RAYS: ❑ Non fasting LIPID PANEL @ 11 yo

ASSESSMENT: □ Well child: normal growth & development for age

PLAN: ❑ Fluoride supplementation (as needed locally)
❑ Immunizations per clinic schedule
❑ Optometry Referral
❑ Sports Physical Form/Health Assessment form completed/returned

F/U: at next well child visit at ___ years, sooner if parental concerns
□ Patient and/or parent verbalizes understanding of treatment and plan □ Anticipatory guidance handout provided

PREVENTION: □ Dental visits □ Safety/Falls □ Bike Helmet □ Booster Seat □ Tobacco avoidance □ Sun safety
□ Exercise □ Nutrition □ Media Time

Signature:_____
Date:
Stamp:

RECORDS MAINTAINED AT: ▶		
PATIENT'S NAME *(Last, First, Middle Initial)*		SEX
RELATIONSHIP TO SPONSOR	STATUS	RANK/GRADE
SPONSOR'S NAME		ORGANIZATION
DEPART./SERVICE	SSN/IDENTIFICATION NO.	DATE OF BIRTH

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